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Homosexuality among women: historical and current views in psychology

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AN ABSTRACT OF THE THESIS OF Craig Bracy for the Master of Science in Psychology presented July 27, 1976.

Title: Homosexuality Among Women: Historical and Current Views in Psychology.

APPROVED BY MEMBERS OF THE THESIS COMMITTEE:

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The purpose of this review is to evaluate the methodology of past and present research with female homosexuals and then to summarize the current state of knowledge in psychology and psychiatry. The data presented in this review have been derived predominantly from material abstracted in the Medicus Index (1900-1976) and the Psychological Abstracts (1927-1976).

This reviewer has established specific criteria by which all studies throughout this literature review will be examined. These are: sample size, sampling of experimental and control groups, variables controlled

(age, education, etc.), How sexual orientation was determined, and tests and questionnaires employed, their reliability, validity, administration, and interpretation.

It has been shown that both the clinical and nonclinical research populations are extremely biased. Historically and currently, the clinical researchers have utilized small and unspecified populations. This type of research is usually in the form of case studies and has been psychoanalytically oriented. Currently, clinical researchers have attempted to overcome the methodological problems by using control groups, standardized tests, statistical analysis of data, etc. However, adequate clinical studies have been few and their findings highly tentative. The most serious problem with the clinical research is sampling.

Nonclinical research, on the other hand, has used samples comprised of young, white, educated, and middle class subjects.

Researchers have attempted to find objective criteria that would discriminate between heterosexual and homosexual women, using projective techniques and self report inventories, but their results are inconclusive. Data have shown, however, that there are significant differences between "butch" and "fem" lesbians and male homosexuals. Future research will need to determine the sex role preference of both the homo-

sexual and heterosexual groups, otherwise differences between the two groups may be the result of a larger proportion of "butch" lesbians being compared to "fem" heterosexuals.

The etiology of female homosexuality has been an enduring topic in psychology and psychiatry. To date, researchers have not found any genetic or hormonal characteristics associated with the phenomenon of homosexuality in women. Research focusing on the psychodynamic aspects of homosexuality have found that lesbians have poorer relationships with both parents, experience more interparent friction and less family security, feel less feminine, and are less accepting of the feminine role than heterosexual women. Although these are statistically significant differences between heterosexual and homosexual women it is unknown how, or even whether they affect the development of homosexuality.

Female homosexuality has been considered by many mental health professionals as a disease, neurosis, or degenerative condition. The data have failed to show that female homosexuals are less well-adjusted than their heterosexual controls.

The treatment of female homosexuality has almost been completely neglected. The majority of the literature has reported on the techniques and theories used on male homosexuals. The few studies that have used

female homosexuals are methodologically inadequate. They did not use control groups, standardized instruments to measure the degree of change of sexual orientation, or adequate follow-up studies. Extensive research needs to be completed to determine if the techniques and theories derived from the treatment of male homosexuals are applicable to lesbians.

Considerable more research in the areas of etiology, diagnosis, and treatment of female homosexuality needs to be completed before any tentative statements can be made.

HOMOSEXUALITY AMONG WOMEN: HISTORICAL AND
CURRENT VIEWS IN PSYCHOLOGY

by

Craig Bracy


A thesis submitted in partial fulfillment of the
requirements for the degree of

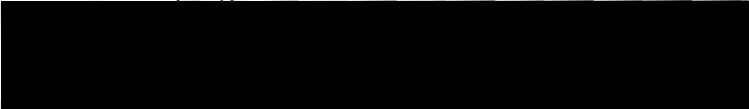
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TO THE OFFICE OF GRADUATE STUDIES AND RESEARCH:


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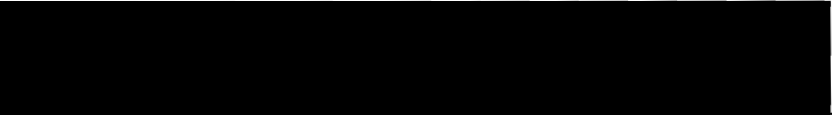

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CHAPTER I

INTRODUCTION

Though female homosexuality was recorded in ancient civilizations (Ellis, 1905; Kinsey, Pomeroy, Martin, & Gebhard, 1953) it was not until 1870 that the first detailed case history of a homosexual women was published. In this case history, Westphal concluded that female homosexuality was the result of a congenital condition. The controversy over the etiology of female homosexuality has been an enduring topic. On one side, some investigators favor a hereditary or biological component, while others emphasize predominantly environmental factors. Arguments have also raged within such areas as psychopathology, diagnosis and treatment of lesbians.

Early investigators assumed that the incidence of female homosexuality was as prevalent as male homosexuality (Brill, 1935; Ellis, 1905). However, it was not until Kinsey et al. (1953) published their studies on male and female sexual behavior that homosexuality among both sexes was estimated. According to their research, approximately 4% of the male and 1% to 2% of the female population in the United States are exclusively homosexual. Their research also showed that 28% of the female and 50% of the male sam-

ple they studied had been conscious of specifically erotic responses to members of their own sex. The accumulative incidence of homosexual responses to the point of orgasm reached 13% and 37% in the total female and male population respectively. It is suggested by recent research that homosexual behavior, either as a transitory phenomenon or as an exclusive sexual orientation is considerably less frequent in females than males in the United States (Kinsey, et al., 1953).

I METHODOLOGY

The purpose of this review is to evaluate the methodology of past and present research with female homosexuals and then to summarize the current state of knowledge in psychology and psychiatry. The data presented in this review have been derived predominantly from material abstracted in the Medicus Index (1900-1976) and the Psychological Abstracts (1927-1976).

Research in the area of female homosexuality needs to be assessed in a thorough and systematic manner. To date, there has not been a review which has attempted to evaluate the methodology of existing research. Unfortunately, the methodology has been neglected, while the results of the studies have been used to substantiate various views and theories of female homosexuality. The reliability and validity of their results are dependent upon sound methodology.

This review establishes specific criteria by which all studies throughout this literature review will be examined.

Sample Size

Sample size is an important variable in all research because it determines, in part, the extent to which the results can be generalized. Extremely small samples may be unrepresentative of the larger population, thereby restricting or invalidating the researchers' results.

Experimental and Control Groups

The type of sample will also limit the extent to which generalizations can be made to the entire population of female homosexuals. If college students are used, then the results can be generalized only to a more educated population. Samples of outpatients, inpatients, gay bar patrons, and members of homophile organizations are other examples of relatively homogeneous populations that will introduce different types of bias. It is impossible to select a representative sample of lesbians. Biased populations are the rule in this type of research. Specific types of biases will be discussed later.

Careful consideration needs to be given to the type of heterosexual control group chosen. Control groups, like experimental groups may be biased in certain directions. Using women's groups, church groups, etc., all introduce particular types of bias.

Controlled Variables

Because homosexual populations tend to be biased in specific directions (e.g. clinical populations, college students, etc.), it becomes necessary for the experimental and control groups to be matched on certain variables such as age, education, occupation, or marital status. The types of variables that will need to be controlled will, of course, depend on the populations sampled.

When groups are matched on particular variables, the possibility of finding any relationship between those variables and sexual orientation is eliminated. This must be taken into account when interpreting the results of studies in which such controls have been employed.

Determining Sexual Orientation

It is important to determine what techniques were used in determining homosexuality and heterosexuality. Were the subjects self-proclaimed homosexuals and heterosexuals or did the researchers use the Kinsey Rating Scale or some other type of standard instrument? With the Kinsey Rating Scale it is possible to determine where each subject places him/herself. The Kinsey Rating Scale is divided into six parts: 0= entirely heterosexual; 1= largely heterosexual, but with incidental homosexual history; 2= largely heterosexual, but with a distinct homosexual history; 3= equally heterosexual and homosexual; 4= largely homosexual, but with distinct heterosexual history; 5= largely homosexual, but with inci-

dental heterosexual history; and 6= entirely homosexual.

The use of verbal statements, or nonstandard techniques, may be quite undependable and subject to considerable bias. For instance, the subject may have never had a sexual experience with someone of her own sex, but merely may have fantasies about it. Or she may have had one or two homosexual contacts such as mutual masturbation or oral genital stimulation with another woman and consider herself exclusively homosexual when in fact she is not.

It may be that neither the Kinsey Rating Scale nor verbal statements are used, but a clinical diagnosis from hospital records. Then the criteria used will vary according to the therapist and his/her theoretical orientation.

Psychological Tests and Questionnaires

The type of test instruments employed need to be examined quite carefully. Were self report inventories or projective techniques used? Objective tests or self report inventories, have standardized administration, scoring, and interpretation, whereas projective techniques vary considerably from examiner to examiner (Klopfer & Taulbee, 1976).

Were all tests administered to both groups under approximately the same conditions or did the conditions and tests administered vary? With mail-out questionnaires and tests, for instance, the experimenter does not have control over the environmental factors that may impinge on the person responding.

These are general guidelines, covering major problem areas, that will be followed throughout this review.

II METHODOLOGICAL EVALUATION OF THE CLINICAL RESEARCH

The majority of the literature on female homosexuality is based on patients or clients seen in private practice. The results from these studies have typically been generalized to all homosexual women, as if their samples were representative. This type of error has been the most prevalent in the literature, as well as the most damaging to the lesbian community. Even the current literature abounds with this type of biased reporting (Bergler, 1948; Socarides, 1970). Most of the research has been in the form of case studies, which lack the methodological essentials for sound generalizations. These studies, however, have had a profound impact on current views and theories of female homosexuality (Bergler, 1948; Ellis, 1905; Freud, 1933; Krafft-Ebing, 1965; Socarides, 1970).

Sample Size

It is usually impossible to determine the size of the sample because the majority of the writers in the clinical area do not specify their sample size (Bergler, 1948; Freud, 1933; Socarides, 1970).

Krafft-Ebing (1965) formulated his theory of female homosexuality from a sample of seventeen women. Havelock

Ellis (1905) studied less than thirty female homosexuals and Sigmund Freud's theory of female homosexuality appears to be based on only one case (Freud, 1920).

Current clinical researchers, using sound methodological approaches have attempted to use larger sample sizes than their predecessors (Howard, 1962 (N=51); Kaye, Berl, Clare, Eleston, Gershwin, Gershwin, Kogan, Torda, & Wilbur, 1967 (N=48); Swanson, Loomis, Lukesh, Cronin, & Smith, 1972 (N=80)).

Experimental and Control Groups

Krafft-Ebing (1965) used the case study approach to the study of female homosexuality. His subjects demonstrated various signs of psychopathology such as neurosis (neurasthenia) or psychosis (paranoia, etc.), but it is unknown how or from what population his sample was drawn, since he did not specify. Ellis' data were derived from a sample of predominantly "butch" or masculine appearing women, according to his descriptions (Ellis, 1905). Again, it is not known where he drew his sample from or how he sampled. Krafft-Ebing (1965) and Ellis (1905) did not use control subjects.

In a more recent study, Howard (1962) used a sample of female homosexual delinquents who were incarcerated. He was interested in studying the determinants of sex role identification. His sample contained 28 "vots" (girls who had adopted a masculine appearance and style) and 23 "chicks" (girls who had maintained their feminine appearance and

style). The girls ranged in ages from 15 to 17 years and were from diverse ethnic backgrounds and socioeconomic levels, according to the author. However, since he did not give any breakdowns according to age, race, socioeconomic status, etc., the groups could have been composed, for example, of very young girls, with a tendency toward lower class minorities, instead of a more balanced sample. Since these variables were not described they are unknown.

The problem with using a young population such as Howard's is that their homosexual behavior may be another form of acting out, rather than a permanent and stable sexual orientation. He also did not use a control group of nonhomosexual delinquents.

Kaye, et al. (1967) in their study contacted 150 psychoanalysts and secured a sample of 24 lesbians and 24 heterosexual women who were currently in psychoanalysis. The investigators demonstrated their biases when the controls were selected and matched with the experimental subjects on amorphous categories of "sexual maladjustment" and "poor childhood experiences." Nevertheless, they approached their study quite realistically. For instance, they did not make any claims that their sample was representative of homosexuals in general, though they did feel that their sample was representative of lesbians in therapy. However, they only sampled psychoanalysts and their patients, which is not representative of psychotherapists or lesbians in therapy. Because of the

cost psychoanalysis is a luxury of the upper class, thereby excluding the majority of lesbians in therapy.

In another study, Swanson, et al. (1972) studied an outpatient sample of 40 homosexual and 40 heterosexual women. They matched these women according to age and psychiatric diagnosis other than homosexuality. For example, if a homosexual woman had a primary diagnosis of schizophrenia she was then matched with a control subject who also had a primary diagnosis of schizophrenia. The only variable that was manipulated was sexual orientation. They then examined their hospital charts for 45 different items such as presenting psychiatric complaint, childhood adjustment, parental factors, adult social and work adjustment. Swanson, et al. (1972) wanted to determine what the clinical characteristics were of homosexual women in therapy. They sampled only one type of clinical setting, which is not representative of lesbians in therapy.

Using clinical populations presents special types of problems. Pathology is a confounding variable since it is difficult to determine how much the particular disorder contributes to the results.

Determining Sexual Orientation

Usually, no attempt is made to define homosexuality (Bergler, 1948; Ellis, 1905; Freud, 1933; Krafft-Ebing, 1965; Socarides, 1970). When an attempt is made to define it the criteria are often quite vague and hardly operational

(Howard, 1962; Kaye, et al., 1967; Swanson, et al., 1972). Swanson, et al. (1972), for example, state; "Forty patients were found whose records and therapists indicated that the patients had a sexual attraction toward other women and a history of female homosexual activity" (p. 120). The criteria are unknown, since they were determined by the patient's therapist.

Psychological Tests and Questionnaires

Early investigators and many contemporary clinicians have not employed any type of psychological testing, but have relied completely upon diagnostic interviews, dream material, etc. (Bergler, 1948; Ellis, 1905; Freud, 1933; Krafft-Ebing, 1965; Socarides, 1970). A few contemporary researchers who have studied clinical populations, used self report inventories, projective techniques, and statistical analysis (Howard, 1962; Kaye, et al., 1967; Swanson, et al., 1972).

Howard (1962) in his study of female homosexual delinquents employed such tests as the Rorschach Inkblot Technique, Thematic Apperception Test (TAT), Draw-A-Person Test (DAP), and the Masculinity-Femininity Scale (M-F) from the Minnesota Multiphasic Personality Inventory (MMPI). All tests were administered and scored by the author. The test protocols were reviewed by ten judges who then filled out a standardized checklist that tapped such areas as mother-daughter relationship, father-daughter relationship, etc. The judges could refer back to the test protocols, if needed, as they

filled out the checklist. The checklist was extremely biased. For instance, under the section on the girl's mother these were the questions:

I. Rejection by the mother:
Strength: 0 100

Is the mother seen as (check as many as is appropriate):

1. nonexistent or dead
(this was intended to mean emotional distance or absence of a warm relationship between the girl and her mother, but was not explained by the author to the judges).
2. cold and ungiving
3. not satisfying dependency wishes
4. threatening and destroying
Strength: 0 100

5a. seen as passive in the family configuration
5b. seen as aggressive in the family configuration
6. fear of mother, if any
Strength: 0 100
(Howard, 1962 p. 70).

The judges were not aware of the girls' sexual orientation, but were aware that they were juvenile delinquents. This knowledge in conjunction with the checklist may have produced a psychological set or halo effect which may have influenced the judges perceptions of the test data.

The masculinity-femininity scale from the MMPI is not an adequate test for females, because it is not known what inferences can be made from high or low scores (Klopfer, 1976, personal communication). The scale is bipolar with masculinity and femininity being mutually exclusive. A high score for women (greater than two standard deviations) would

indicate that they answered the questions in a masculine direction, while a low score would indicate they answered the questions in a feminine direction. However, it should be kept in mind that the original standardization groups were heterosexual and homosexual men and contained no women. Active supporters of womens' liberation have been known to score low on the M-F scale, creating a conflicting picture (Klopfer, 1976, personal communication).

The DAP was used under the assumption that the first sex drawn (male or female) is indicative of the individual's self concept. In other words, women who draw a female figure first are assumed to have a better self concept than those women who draw a male figure first. In recent years this assumption has been challenged, with current data showing this to be inaccurate (Craddick, 1963). Craddick (1963) found that college females typically draw a male figure first rather than a female figure.

Kaye, et al. (1967) had psychoanalysts fill out a twenty-six page questionnaire on their homosexual and heterosexual clients. Their theoretical orientation may have seriously influenced the direction of their answers, while some of their responses may in fact have been interpretations rather than facts communicated by the analysand. For example, according to Bieber, et al. (1962) and their research with psychoanalytic clients, the typical family constellation of male homosexuals is a weak and ineffective father with a

closebinding and domineering mother. The psychoanalysts completing the questionnaire may have been overly influenced by recent psychoanalytic research and overlook other important data.

Swanson, et al. (1972) examined the experimental and control subjects' hospital charts for 45 different items. Relying on case notes can be quite unreliable, because it may be uncertain as to whether the entries are facts communicated by the patient or an interpretation made by the examining psychologist or psychiatrist. It is also unknown whether the reviewers had to make certain interpretations from the data to complete their questionnaire.

III METHODOLOGICAL EVALUATION OF THE NONCLINICAL RESEARCH

Recent researchers have used predominantly nonclinical populations such as members of homophile organizations, college students, etc. (Freedman, 1967; Kenyon, 1968a, 1968b; Wilson & Greene, 1971). However, in relation to the clinical research, nonclinical studies compose a very small percentage of the literature. Until recently clinical studies were the only source of data about female homosexuality. The results of the clinical studies were considered valid indicators of trends and conditions existing among all female homosexuals. This is grossly inaccurate since clinical populations (e.g. private patients, inpatients at private psychiatric hospitals, inpatients at state institutions, etc.) may differ

along such dimensions as education, socioeconomic status, etc. Also, it has been shown in the previous section that clinical populations are unrepresentative of female homosexuals in general.

The use of nonclinical populations has given mental health professionals a different perspective on the phenomenon of female homosexuality.

Sample Size

The sample sizes in most of the studies has been adequate (Armon, 1960 (N=60); Bene, 1965 (N=117); Clingman & Fowler, 1976 (N=128); Freedman, 1967 (N=129); Hassell & Smith, 1975 (N=48); Henry, 1941 (N=40); Hopkins, 1969 (N=48); Kenyon, 1968a, 1968b (N=246); Kremer & Rifkin, 1969 (N=25); Loney, 1972 (N=23); Rosen, 1974 (N=26); Saghir, et al., 1969, 1970 (N=100); Siegelman, 1972 (N=217); Siegelman, 1973 (N=131); Thompson, McCandless & Strickland, 1971 (N=178); Thompson, Schwartz, McCandless & Edwards, 1973 (N=178); Wilson & Greene, 1971 (N=100)).

Experimental and Control Groups

Nonclinical samples, like clinical samples, are equally unrepresentative. Compared to the National Census it is found that they are not a representative cross-section, but are skewed toward younger, better educated and professional types of subjects. The Daughters of Bilitis (1959) an organization for gay women, sent out more than 500 ques-

tionnaires to their members of which 157 (31%) were returned. According to their results, which also may not be representative because of sampling problems, 82% completed high school; 66% had some college; 46% completed four years of college; and 16% went beyond the fourth year of college. The 1960 Census showed that for white, urban females 45% graduated from high school; 9.5% had from 1-3 years of college; and only 6% had four or more years of college. The Daughters of Bilitis figures are also considerably higher than those for white, urban males. Their figures compared to the 1970 Census were still significantly larger with 66% graduating from high school; 12% attending 1-3 years of college; and 9% completing four or more years of college. The average grade for 89% of the respondents, for four years of college, was an "A" or "B" (Daughters of Bilitis, 1959).

The median annual income for 85% of their sample was \$4200. The median annual income for white, urban females older than 14 years was \$1,606 and \$2,516 for the 1960 and 1970 Census respectively.

The study by the Daughters of Bilitis (1959) also showed that 38% had professional occupations; 33% clerical; 6% skilled and unskilled; and 6% were students. In comparison to the 1960 and 1970 Census for white, urban females 14 years and older professional occupations were occupied by 13.4% and 15.3% respectively.

A study by Saghir, Robins, Walbran, and Gentry (1970)

showed that their sample of lesbians, which were obtained through two homophile organizations in San Francisco and Chicago, were young, educated, earned a high income, and occupied a greater percentage of professional positions in the job market than the average woman, according to the 1970 Census.

Similar to clinical studies that have used unrepresentative and biased samples, nonclinical research appears to have encountered the same sampling problem. These statistics do not invalidate their results, but are used only to caution against extreme generalizations.

The majority of the research with nonclinical samples have used women who belong to homophile organizations (Armon, 1960; Bene, 1965; Freedman, 1967; Hopkins, 1969; Kenyon, 1968a, 1968b; Rosen, 1974; Saghir, et al., 1969, 1970; Siegelman, 1972, 1973, 1974), while other studies have used college students (Wilson & Greene, 1971), personal acquaintances and gay bar patrons (Clingman & Fowler, 1976; Hassell & Smith, 1975; Henry, 1941; Loney, 1972; Thompson, et al., 1973) or adolescents (Kremer & Rifkin, 1969).

A few of the studies did not use control groups so meaningful comparisons and statistical analyses could not be made (Henry, 1941; Kremer & Rifkin, 1969; Rosen, 1974).

Most of the researchers controlled for age and education, while other variables controlled varied from study to study. Two variables which are not normally controlled but

should be incorporated are marital status and occupation. Most lesbians are single or involved in some type of a relationship, as well as being self sufficient. For example, Mark Freedman (1967) concluded from his research that lesbians attitudes towards work were more similar to males than to females, however, the control subjects were unemployed, married, and had children.

Nonclinical samples are not representative of lesbians in general because the experimental and control subjects tend to be young, white, educated, middle class, and occupy a greater percentage of professional positions in comparison to the National Census (Hassell & Smith, 1975; Loney, 1972; Saghir, et al., 1969, 1970; Thompson, et al., 1971, 1973; Wilson & Greene, 1971).

Determining Sexual Orientation

The criteria used for including or excluding subjects from the experimental or control group are not clear in most of the studies (Armon, 1960; Bene, 1965; Clingman & Fowler, 1976; Freedman, 1967; Henry, 1941; Kremer & Rifkin, 1969; Loney, 1972; Rosen, 1974; Saghir, et al., 1969, 1970; Siegelman, 1972, 1973, 1974; Thompson, et al., 1971, 1973; Wilson & Greene, 1971).

Kremer and Rifkin (1969), for example, interviewed adolescents who were referred to them by teachers or school counselors who felt they might have a homosexual problem. The criteria they used appeared to be behavioral types of

criteria, but they are completely unknown.

Kenyon (1968a, 1968b) used the Kinsey Rating Scale and found that 96% of the controls were exclusively heterosexual, while only 37.4% of the experimental group were exclusively homosexual. Hopkins (1969) also used the Kinsey Rating Scale, but to be included in the experimental and control group the subjects had to fall between 4-6 and 0-2 respectively. However, there still may be a greater percentage who are exclusively heterosexual than there are homosexual. Hassell and Smith (1975) used only subjects who were exclusively heterosexual and homosexuals who scored 5 or 6 (exclusively or predominantly homosexual) on the Kinsey Rating Scale.

Determining the degree of the person's sexual orientation is extremely important. Even though Kenyon (1968a, 1968b) used members of a homophile organization the range of their sexual orientation was quite apparent on the Kinsey Rating Scale. Studies that do not attempt to control for this problem may be working with a homogeneous control group and a heterogeneous experimental group, in regards to sexual orientation.

Psychological Tests and Questionnaires

There has been only one study which has used projective techniques exclusively in studying personality differences between homosexual and heterosexual women (Armon, 1960). Armon (1960) used the Rorschach Inkblots and the Figure Drawing Test. Both of these tests are highly subjective and vary

considerably in administration, scoring, and interpretation (Klopfer & Taulbee, 1976); however, she did attempt to overcome this problem. The Figure Drawing Tests were scored independently by three judges and the reliability of judgement determined. The reliability of scoring on the Rorschach was checked only when the judges found significant differences between the homosexual and heterosexual groups.

Studies using self report inventories have had some problems. A few of the studies used instruments that did not have sufficient reliability or validity research to support them (Bene, 1965; Kenyon, 1968a, 1968b; Loney, 1972; Wilson & Greene, 1971).

Most of the nonclinical studies have used reliable and valid testing instruments that have been administered under standardized or equivalent conditions to both groups (Clingman & Fowler, 1976; Freedman, 1967; Saghir, et al., 1969, 1970; Siegelman, 1972, 1973, 1974; Thompson, et al., 1971, 1973).

IV SUMMARY OF THE CLINICAL AND NONCLINICAL RESEARCH

Most of the clinical research, historically and currently, has used small and/or unspecified samples (Bergler, 1948; Freud, 1933; Socarides, 1970), subjects who were moderately and/or severely disturbed (Krafft-Ebing, 1965), or subjects comprising a select group of the homosexual population such as "butch" or masculine appearing women (Ellis, 1905).

Clinical researchers have depended heavily upon diagnostic interviews and the case study method as their research tools. Contemporary clinicians are more apt to use their private clients (Bergler, 1948; Socarides, 1970). They, too, have used the case study approach, and like their predecessors, have made the statistical error of generalizing from their private clients to lesbians in general (Bergler, 1948; Socarides, 1970). Both Bergler (1948) and Socarides (1970) are practicing psychoanalysts and have been quite outspoken about the "disease" of homosexuality. Psychoanalysts are not representative of psychotherapists, nor are psychoanalytic patients representative of lesbians in psychotherapy.

To make any broad generalizations from these clinical studies would be a serious mistake, because of the methodological problems and lack of representative samples.

Howard's (1962) study was poorly designed (he used a very young population, lacked a control group, etc.) his results should be disregarded until further research has been completed. The Kaye, et al. (1967) and Swanson, et al. (1972) studies are not representative of lesbians in psychotherapy, because they did not sample a variety of clinical settings. Psychopathology, case notes, and analysts' opinions are confounding factors in these studies, which may greatly distort the results. Their findings are highly tentative and should be used cautiously.

Nonclinical research, on the other hand, have used sub-

jects that are young, educated, and middle class (Hassell & Smith, 1975; Wilson & Greene, 1971). To make any generalizations from these studies to gay women in general would be a serious error too, because they are not representative.

Determining the degree of sexual orientation appears to be one of the most crucial problems with the studies that have been reviewed. It cannot be assumed that if the sample is from a gay organization or the subjects define themselves as homosexual that they are exclusively or predominantly homosexual. Studies have shown that homosexuals vary in their degree of sexual orientation (Kenyon, 1968a, 1968b).

It is apparent that generalizations cannot be made from the clinical or nonclinical research that has been completed to date. Their results may be important to the particular population they have studied, but are not representative cross-sections of the homosexual population.

CHAPTER II

DIAGNOSIS AND CLASSIFICATION OF FEMALE HOMOSEXUALS

I DIAGNOSIS OF HOMOSEXUALITY

The diagnosis of female homosexuality has largely been based on stereotyped indicators of masculine and feminine behavior and physical characteristics (Davenport, 1972; Oberndorf, 1919; Shearer, 1966). Deutsch (1944) explains that these masculine sex characteristics can exert a strong psychological influence on the woman. Feeling femininely inferior and inadequate she may overemphasize her masculine qualities to compensate. Nevertheless, masculine behavior and physical traits are not valid criteria in the diagnosis of female homosexuality, according to some investigators (Gluckman, 1966).

Currently, there are some mental health professionals who use cross sex-typed behaviors and physical characteristics as indicators of homosexuality or homosexual inclinations in young girls (Davenport, 1972; Shearer, 1966). The criteria they have employed are competitiveness, aggression, preference for masculine activities (e.g. playing war, cowboys and Indians, etc.), exclusion of feminine activities (e.g. playing house, nurse, etc.), masculine appearance,

dress, and gestures.

There have not been any studies, to date, that have shown a correlation between tomboy types of behavior during childhood and adolescence and female homosexuality.

Besides stereotyped behaviors and physical traits as criteria of female homosexuality, other writers have suggested that pathological jealousy is evident of a homosexual component (Hirschfeld, 1956; Lagache, 1950; Stekel, 1914). Women who are extremely jealous of a heterosexual male involved in a relationship with a woman may be expressing the following formula, according to some psychoanalysts: She doesn't love me, she loves him.

Female homosexuality may also be "masked" according to Wilhelm Stekel (1914). For example, women who can reach orgasm only by being in the dominant position or women who are frigid and women who are actively involved in the liberation movement may be latent homosexuals (Coriat, 1913; Hirschfeld, 1956; Stekel, 1914).

There is no research to support the concepts of "pathological jealousy" or "masked" homosexuality.

Contemporary researchers have been concerned with the diagnosis of male homosexuality rather than female (Bergmann, 1945; Due & Wright, 1945; Fein, 1950; Goldfried, 1966; Lindner, 1946; Piotrowski, 1957; Schafer, 1954; Stone & Schneider, 1975; Ulett, 1950; Wheeler, 1950). There have been some attempts to establish diagnostic criteria that would be applic-

able to female homosexuals, but the studies have been few, as well as unproductive (Armon, 1960; Fromm & Elonen, 1951; Hopkins, 1970; Ohlson & Wilson, 1974).

Armon's (1960) and Fromm and Elonen's (1951) studies were not specifically designed to study diagnostic criteria for female homosexuality, although they have suggested possibilities for further research. Fromm and Elonen (1951) studied one homosexual using a variety of testing instruments. Their data suggests that female homosexuals deprecate human beings in general and display a disparaging attitude toward men. Armon (1960) found that Rorschach images of female figures were frightening and/or aggressive.

Hopkins (1970) used a sample of 24 homosexuals from the Minorities Research Group and 24 heterosexuals randomly selected from female church groups and hospital colleagues. She wanted to determine whether or not the two groups could be differentiated by various signs on the Rorschach. She concluded from her research that the Rorschach signs used to differentiate male homosexuals from male heterosexuals were not useful with lesbians, because they could not differentiate between the experimental and control group. Hopkins (1970) also tested the Rorschach signs suggested by Armon (1960) and Fromm and Elonen (1951), but did not find them to be statistically significant.

As the result of her research, Hopkins (1970) suggests three possibly significant signs on the Rorschach that may

discriminate between homosexual and heterosexual women. They are: a) average of three or less responses per card, b) deprecated female response to card VII, and c) omission of card VII from the top three "like" cards.

There has not been any Rorschach research since Hopkins' (1970) study, so it is undetermined whether her Rorschach signs can consistently and reliably distinguish between homosexual and heterosexual women.

More currently, Ohlson and Wilson (1974) administered the Minnesota Multiphasic Personality Inventory (MMPI) to 64 female homosexuals and 64 heterosexuals. All subjects completed the Kinsey Rating Scale and only those who were exclusively homosexual and heterosexual were included in the study. They also controlled for age and education.

They found that three of the 13 MMPI scale significantly differentiated between the homosexual and heterosexual groups. The heterosexual group scored significantly higher on the Hypochondriasis ($p < .05$), Hysteria ($p < .05$), and the Psychasthenia ($p < .05$) scales. Also, 57 out of the 566 items discriminated between the two groups. Eighteen of the items were filler questions leaving 38 items of interpretive value. These items were grouped into six related areas: a) lower anxiety, b) fewer physical complaints, c) masculine orientation, d) social introversion, e) religion, and f) overt homosexuality.

Whether or not these differences are stable indicators

can only be determined through cross validation studies. Their statistically significant results may be the result of random fluctuations of a number of variables, rather than significant differences.

Neither projective techniques (Hopkins, 1970) nor self report inventories (Ohlson & Wilson, 1974) have been definitively established as productive instruments in the diagnosis of female homosexuality.

II CLASSIFICATION OF FEMALE HOMOSEXUALS

Psychiatrists during the middle and late 19th century developed elaborate typological systems for the classification of homosexuals. Krafft-Ebing (1965; this is a recent translation of his work), an early investigator in the area of female homosexuality, first determined whether the condition was the result of acquired or congenital factors. This depended on certain characteristics and conditions of the person, as well as her past history. He then further divided each category (acquired and congenital) into four progressive stages, each depicting the characteristics and severity of the condition. Acquired and congenital cases of female homosexuality are considered the result of an "hereditary predisposition" according to Krafft-Ebing (1965). The main distinction between acquired and congenital homosexuality is that in acquired cases heterosexuality dominates the woman's sexual life during the early part of her sexual

development, but then, due to certain factors (e.g. masturbation, etc.) her "hereditary predisposition" is aroused and homosexuality develops. Congenital cases, on the other hand, are women who have had sexual feelings for other women ever since they can remember. There does not appear to be any precipitating environmental factors.

He emphasizes homosexual "feelings" rather than homosexual behavior because genuine homosexuality (women whose sexual orientation is exclusively or predominantly homosexual) and pseudo-homosexuality (situational homosexuality such as in prisons, etc.) become confounded when using behavior as a criterion.

Acquired cases of homosexual feelings demonstrate the following characteristics:

1. The homosexual instinct appears as a secondary factor, and always may be referred to influences (masturbatic, neurasthenia, mental) which disturbed normal sexual satisfaction. It is however, probable that here, in spite of powerful sensual libido, the feeling and inclination for the opposite sex are weak from the beginning, especially in a spiritual and aesthetic sense.
2. The homosexual instinct, so long as sexual inversion has not yet taken place, is looked upon, by the individual affected, as vicious and abnormal, and yielded to only for want of something better.
3. The heterosexual instinct long remains predominant and the impossibility to satisfy it gives pain. It weakens in proportion as the homosexual feeling gains in strength. (p. 351).

Hereditary predisposition will determine at which stage individuals are placed in Krafft-Ebing's (1965) typological system.

The four stages of acquired homosexual feelings are:

1. Simple Reversal of Sexual Feeling

Members of the same sex have sexual feelings toward one another. They sense that their feelings are abnormal and usually seek help at this stage.

2. Defemination

If treatment is not started in the first stage they will undergo a character change and become more masculine in their thoughts and feelings. They will play the sexually active role instead of passively indulging in sexual relations.

3. Stage of Transition to Change of Sex Delusion

At this point they begin to perceive a change in their body (breasts become smaller, maybe even disappearing, pelvis becomes narrower, etc.). Their gait may become more masculine, as well as their mannerisms and speech.

4. Delusion of Sexual Change

In this final stage they perceive themselves as having changed sex. This stage eventually results in paranoia and severe psychosis. (pp. 228-265).

It is apparent that Krafft-Ebing (1965) does not distinguish between the "butch" and "fem" role, but considers the "butch" role as a stage in this degenerative process.

Congenital homosexual feelings, according to Krafft-Ebing (1965) are demonstrated by the following characteristics:

1. The homosexual instinct is the one that occurs primarily, and becomes dominant in the sexual life. It appears as the natural manner of satisfaction, and also dominates the dream life of the individual.
2. The heterosexual instinct fails completely, or, if it should make its appearance in the history of the individual (psychosexual hermaphroditism), it is still but an episodic phenomenon which has no root in the mental constitution, and is essen-

tially but a means to satisfaction of sexual desire. (pp. 351-352).

The four stages of congenital homosexual feelings are:

1. Psychosexual Hermaphroditism

The sexual instinct is predominantly homosexual, while some traces of heterosexuality are noticed.

2. Homosexuality

The sexual instinct is directed exclusively toward another person of the same sex. There are no serious changes in their personality or character at this stage.

3. Viraginity

During their childhood they indulge in and prefer masculine activities with boys. They dress in masculine attire and are attracted to virile types of occupations. Their feelings, thoughts, and character are masculine in nature.

4. Hermaphroditism and Pseudo-hermaphroditism

Their body characteristics are masculine while their genitals are completely differentiated and feminine. (p. 265).

Within Krafft-Ebing's (1965) classification scheme are transsexuals (women whose gender identity is masculine rather than feminine), transvestites, and "butch" types. They are not treated as separate phenomena, but are considered as progressive stages.

Havelock Ellis (1905) did not develop an intricate classification system like his contemporary Krafft-Ebing (1965; this is a recent translation); however, he did state that there were various grades of homosexuality. He delineates several characteristics and conditions found in women whose sexual inversion is slightly or severely apparent.

Women whose sexual inversion is only slight are usually not repelled or disgusted by sexual advances of other women. They tend to be unattractive to the average man, which predisposes them to homosexual advances. Their face is plain and lacking symmetry, but they do have attractive figures, even though their physical development (breast development, etc.) is inferior compared to the average women. Sexually (homosexually or heterosexually) they are not very active, but are quite affectionate.

The characteristics of actively inverted women, according to Ellis (1905), are quite apparent. They tend to be masculine in appearance. Their muscles are firmer, their voices deeper, and their sexual organs appear arrested and infantile (small vagina, ovaries missing, etc.). They prefer male attire, but when they do wear feminine garments they are usually simplistic and masculine in style. Their gestures and habits are mannish and they have a strong taste for cigarettes and cigars. They usually dislike domestic work and favor athletics.

Magnus Hirschfeld (1956), on the other hand, categorizes homosexuals according to the age ranges they are attracted toward: children, adolescents, middle age women, or old women.

Freud (1962) describes three classes of homosexuals:

1. Absolute Inverts

Their sexual objects are exclusively of their own sex.

2. Amphigenic Inverts

They are bisexual and do not demonstrate exclusiveness.

3. Contingent Inverts

They seek their own sex for sexual gratification when environmental restrictions prevent heterosexual gratification (prison, etc.).

The previous classification schemes (Ellis, 1905; Freud, 1962; Hirschfeld, 1956; Krafft-Ebing, 1965) were based on clinical populations.

Currently, there has been only one study comparing "butch" and "fem" homosexuals. Clingman and Fowler (1976) studied the gender roles of 62 male and 66 female homosexuals. They were divided into the following groups: a) FF or female "fem", b) FB or female "butch", c) FO or female "other", d) MF or male "fem", e) MB or male "butch", and f) MO or male "other". All groups were administered the Adjective Checklist and a multiple discriminant analysis was performed on the mean standard scores of all six groups, but the results did not reach statistical significance. They then excluded the FO and MO groups and performed the same analysis and found statistically significant results.

The FF group was higher on Succorance, Abasement, and Deference than the FB group. The FF group scored higher on Counseling Readiness than the MB group, while the MB group scored higher than the FF group on heterosexuality.

The MF group were higher on Succorance, Abasement, Deference, and Total Number of Items Checked (data has shown

this to be a feminine trait. Gough & Heibrun, 1965) then the FB group, while the FB group scored higher on Self-confidence, Dominance, Autonomy, and Aggressiveness.

These reported differences are significant at the .05 level of significance.

Their results (Clingman & Fowler, 1976), although tentative, show that male and female homosexuals, who adopt a specific gender role demonstrate significant personality differences. The Daughters of Bilitis (1959) found that 37.6% of their sample preferred a masculine role, 21.2% a feminine role, while 36.3% did not report a preference, but stated that they vacillated between a masculine and feminine role.

III SUMMARY

Investigators, using projective techniques (Hopkins, 1970), as well as self report inventories (Ohlson & Wilson, 1974), have attempted to find objective criteria that would discriminate between homosexual and heterosexual women, but their results are inconclusive. Hopkins (1970) using the Rorschach Inkblots and Ohlson and Wilson (1974) using the MMPI have found possible indicators through their research, but their studies have not been cross-validated, so their results are highly tentative.

Recently, there has been some controversy over the assessment of sexual orientation (Anderson, 1975; Stone &

Schneider, 1976). Anderson (1975) in her reply to a study by Stone and Schneider (1975) unfairly indicts them, as well as other investigators who are attempting to find indicators that differentiate between homosexuals and heterosexuals when she states:

This writer believes that such phenomena as the Wheeler signs of homosexuality in the Rorschach may "possess considerable utility" only for those defensive clinicians who will not or cannot engage the client in a meaningful existential encounter about the integrated personality where self-revelation concerning all relevant phenomena and their myriad forms of interaction is part of the process. (p. 581).

Stone (1976), on the other hand, feels that psychological assessment is primarily concerned with a greater awareness and understanding of the individual. He states:

We consider a person's sexual behavior and attitudes to constitute one of the factors that exerts a significant influence on major portions of that person's life. Therefore, we consider the clinician's failure to assess, understand and comprehend the person's sexual behavior and attitudes to be a gross error, one committed at the client's expense. (p. 55).

Data concerning a person's sexual behavior should not be disregarded nor should research in this area be abandoned.

The extensive classification systems of Krafft-Ebing's (1965) and others has become an historical artifact. Current investigators have not attempted to develop intricate classification schemes. In fact, most of the studies reviewed neglected to differentiate between those who adopt a predominantly feminine, masculine, or androgynous role (Freeman, 1967; Kenyon, 1968a, 1968b). Clingman and Fowler (1976) have found significant differences between those who adopt a

masculine or feminine gender role. Psychological differences that have been found between homosexual and heterosexual women may have been influenced by the person's gender role, which was not controlled by the researchers.

CHAPTER III

PREDISPOSING FACTORS IN FEMALE HOMOSEXUALITY

I GENETIC THEORY

A genetic theory of homosexuality is prevalent in early writings (Ellis, 1905; Forel, 1925; Krafft-Ebing, 1965). Though there have been some attempts by current investigators to discover a genetic component in male homosexuality, they have been unsuccessful (Kallmann, 1952).

A survey by Morris (1973) of 150 psychiatrists and 150 general practitioners, of which 70% of the questionnaires were returned, showed that 42% thought homosexuality was inborn. Kenyon (1968b) found in his study that 57% of the homosexual subjects and 55% of the heterosexuals thought that homosexuality was inborn.

Presently, there have not been any well controlled studies with female monozygotic and dizygotic pairs. Two cases of overt homosexuality in monozygotic twins have been reported in the literature, but evidence of a genetic component in the development of female homosexuality has not yet been found (Pardes, Stinberg, & Simons, 1967; Perkins, 1973).

At this time the evidence is inconclusive as to the

role of genetics in the etiology of female homosexuality.

II HORMONAL THEORY

Some researchers have attempted to explain female homosexuality as a result of hormonal imbalances (Ellis, 1905). However, there is not any conclusive evidence to suggest that female homosexuality is a result of a hormonal abnormality.

Lorraine, Ismail, Adomopoulos, and Dove (1970) studied the hormonal level in the urine of four homosexual women. They did find significant hormonal differences between the experimental and control groups, however, the sample is so extremely small that it would be a serious error to make any generalizations until larger samples have been studied.

Griffiths, Merry, Browing, Eisinger, Huntsman, Lord, Polani, Tanner, and Whitehouse (1974) examined the hormonal level in the urine of 42 members of a lesbian organization. Urinary levels of oestrone, oestradiol, oestriol, pregnane-diol, 17-oxosteroids, 17-hydroxycorticosteroids, testosterone, and expitestosterone were determined, but no consistent pattern of a hormonal abnormality emerged.

Due to the paucity of material in this area, it is inconclusive whether hormonal imbalances are a significant factor in the etiology of female homosexuality.

III PSYCHODYNAMIC THEORY

Gartrell, et al. (1974) polled the 908 active members of the Northern California Psychiatric Association. Forty two percent of the questionnaires were returned. They found that 87% thought that female homosexuality was a learned condition, while 84% thought it was the result of disturbed parent-child relationships.

Historically, Sigmund Freud was the impetus behind the psychodynamic approach to the study of human behavior. He was primarily concerned with psychodynamic factors and their effect on the development of female homosexuality. However, in his important work, Three Essays on the Theory of Sexuality (Freud, 1962), he stated that neither innate nor acquired etiological hypotheses were adequate in explaining homosexuality. A bisexual disposition as well as environmental factors were involved (Coriat, 1913; Farnell, 1943; London, 1933; Stekel, 1914, 1930), but the role of bisexuality was not clear. Freud did not investigate the role of bisexuality in the genesis of female homosexuality because he thought that environmental and psychological factors were a more productive and accessible area of study for psychoanalysis to investigate, while the biological aspects of female homosexuality should be left for biology to study (Freud, 1962).

The development of female homosexuality is not as well documented or as thoroughly discussed as male homosexuality by Freud. However, in his New Introductory Lec-

tures on Psychoanalysis (Freud, 1933) he does delineate, however vaguely, the development of female homosexuality. According to Freud (1933) it is a combination of extreme hate for the mother and disappointments in her relationship with her father that she finally regresses to her earlier masculinity complex, which may then lead to overt homosexuality. Not all women, however, who have a masculinity complex are homosexual.

Freud's writings have profoundly affected current views of homosexuality in women. In the process hereditary, congenital, and biological theories have been neglected, for the most part, while psychodynamic theories have become dominant in the area (Allen, 1947; Clippinger, 1971; Coriat, 1913; Gershman, 1953; Kinsey, et al., 1953; Moore, 1945; Socarides, 1972; Stekel, 1930).

Hoffman (1969) sees the overemphasis on environmental factors as a hazard in the scientific investigation of homosexuality. He states:

One hazard of theoretical work in psychology is psychologism: overemphasis on psychological factors in explaining puzzling phenomena. Psychologism plagues the study of homosexuality. (p. 43).

The factors that investigators have indicated as significant in the etiology or predisposition of female homosexuality cover a diverse range of parent-child relationships, heterosexual and homosexual experiences, etc. Of course, most researchers view the etiology of homosexuality as multi-dimensional.

Listed below are factors that clinical researchers have identified as being significant in the development of female homosexuality. These factors were not derived from controlled studies, but are the result of extensive case studies with private patients, inpatients, etc.

- 1). Fear, anxiety, disgust, and rejection of the opposite sex (Adler, 1967; Brody, 1943; Horney, 1937; Krafft-Ebing, 1965; Laycock, 1950; Meagher, 1929; Piotrowski, 1967; Rancourt & Limoges, 1967).
- 2). Tyrannical males within the family system may produce hostility and abhorrence toward men, increasing the likelihood of homosexuality (Brody, 1943; Meagher, 1929; Piotrowski, 1967; Symonds, 1967).
- 3). Unhappy heterosexual relations may leave them with a feeling of revulsion and hostility toward men (Coriat, 1913; Ellis, 1905; Krafft-Ebing, 1965; Meagher, 1929).
- 4). Some homosexual women come from homes where the father was physically abusive toward the mother, creating hostility and aversion toward males (Sylvan & Schaffer, 1949).
- 5). The fear of dominance and destruction through bodily penetration of the penis (Keiser & Schaffer, 1949; Rancourt & Limoges, 1967; Robertiello, 1973).
- 6). Fear of pregnancy (Krafft-Ebing, 1965; McCreary, 1950; Rancourt & Limoges, 1967).
- 7). Fear of venereal disease (Krafft-Ebing, 1965, McCreary, 1950).
- 8). Fallacies about sex conveyed to the child from the parents (Henry, 1941; Krafft-Ebing, 1965; McCreary, 1950).
- 9). Forced celibacy during adolescence (Farnell, 1943).
- 10). Birth of a sibling during puberty (Deutsch, 1944; Freud, 1920b; Sylvan & Schaffer, 1949).
- 11). Unsatisfactory relations between parents may

create an aversion for heterosexual relations (McCreary, 1950).

- 12). Rejecting, critical, domineering, and controlling mothers. The daughters do not identify with their mother's or women in general (Allen, 1954; Bergler, 1943; Biever, 1969; Brody, 1943; Davenport, 1972; Gershman, 1957; Cluckman, 1966; Hamilton, 1939; Laycock, 1950; Meagher, 1929; Rancourt & Limoges, 1967; Robertiello, 1973; Shearer, 1966; Symonds, 1969).
- 13). Rejection by one or both parents from birth or a prolonged period of rejection during childhood (Blackman, 1950, 1953; Sylvan & Schaffer, 1949).
- 14). Unable to find a protective person in the home the girl will seek elsewhere for someone who will satisfy her dependency needs; leaving herself vulnerable to homosexual seduction (Moore, 1945).
- 15). Young girls with low self esteem will usually cling to their own sex because it is less frightening (Thompson, 1947).
- 16). Lacking a sense of femininity women avoid sexual relations, as well as emotional relationships with men (Gershman, 1966; Henry, 1941).
- 17). An impaired or devalued self image may stimulate them to look for their ego-ideal in other women (Kaplan, 1967; Weiss, 1957).
- 18). Being treated as the opposite sex by their parents, who were disappointed in their sex. The result is a distortion in their gender identity (Adler, 1955; Adler, 1967; Davenport, 1972; Henry, 1941; McCreary, 1950; Moore, 1945; Socarides, 1970; Symonds, 1969; Thompson, 1947).
- 19). Homosexual women come from sexually repressive families where everything that pertains to sex is viewed as vulgar and obscene, inhibiting heterosexual adjustment (Farnell, 1943; Meagher, 1929; Neustatter, 1954; Rancourt & Limoges, 1967).
- 20). Homosexual experiences during childhood and early adolescence may promote a homosexual orientation or fixate them at the homosexual stage of development (Ellis, 1905; Henry, 1941; Meagher, 1929; Moll, 1913; Moore, 1945; Owensby, 1941).

- 21). Children of the same sex who sleep together may encourage and stimulate homosexual behavior (McCreary, 1950).
- 22). Many homosexual women during childhood and adolescence experienced a very strong and intense relationship with their fathers. Often times identifying with them (Allen, 1954; Davenport, 1972; Gershman, 1957; Gluckman, 1966; Hamilton, 1939; Meagher, 1929; Shearer, 1966; Sherman & Sherman, 1926).
- 23). The early loss of a parent can retard normal psychosexual development. The surviving parent whether the mother or the father, may absorb the child's interest, becoming overly protective and possessive and unintentionally encourage a homosexual life style (Meagher, 1929).
- 24). Father's of homosexual women are often characterized as being detached and disinterested in their daughter's development. They seldom display any open affection toward them (Davenport, 1972; Deutsch, 1944; Rancourt & Limoges, 1967; Bieber, 1969).
- 25). Fathers of lesbians are often times overly protective, possessive and extremely jealous of their daughter's romantic attachments (Bieber, 1969; Davenport, 1972; Moore, 1945).
- 26). Excessive masturbation in childhood and adolescence (Ellis, 1905; Krafft-Ebing, 1965; Oberndorf, 1919).
- 27). Segregating males and females favors the development of homosexuality, e.g. prisons, schools, military, etc. (Ellis, 1905; Krafft-Ebing, 1965; Meagher, 1929).
- 28). Defiance of parents and society (Rancourt & Limoges, 1967; Robertiello, 1973).
- 29). Extreme adult narcissism favors the development of homosexuality. They love those who love themselves (Brill, 1929; Meagher, 1929).
- 30). A very strong and intense fixation toward a brother or sister may affect the love object choice (Meagher, 1929).

- 31). Heterosexual seduction during childhood or adolescence (Sylvan & Schaffer, 1949).
- 32). Religious and moral taboos against heterosexual relations may inadvertently condition homosexual behavior (Henry, 1941).

Current researchers have not attempted to examine most of the etiological factors suggested by the above clinical investigators. The few clinical studies that have been completed do indicate some common trends (Bene, 1965; Kaye, et al., 1967; Swanson, et al., 1972).

Bene (1965) found that lesbians feared and viewed their fathers as fussy, nagging, bad tempered, and complaining. They also expressed feelings of resentment, bitterness, and hatred more often toward their fathers. Their fathers were characterized as weak, uninvolved in family affairs and child rearing, though he did make the major decisions.

Lesbians perceived their parent's as less loving, happy and pleasant. Significantly fewer lesbians wanted to be like their mothers (homosexuals, 8%/heterosexuals, 28%). In fact fewer lesbians wanted to model themselves after either parent.

The lesbians reported more often than the controls that their parents wanted a boy rather than a girl (homosexuals, 38%/ heterosexuals, 13%; $p < .01$).

Kaye, et al. (1967) found that the lesbians felt more accepted by their mothers and were less afraid that their assertiveness would anger their mothers or make them sick than the controls ($p < .05$). The fathers were feared and

characterized as puritanical with a tendency to ally with the daughter against the mother. They were overly concerned with their daughter's physical health and satisfied their own needs by exploiting them. The fathers also reacted negatively when affection was displayed between the daughter and her mother ($p < .05$).

Kaye, et al. (1967) also found that lesbians received more threats of punishment for sex play with boys than the heterosexuals ($p < .05$). They also tended to physically fight with other children during adolescence and childhood; they disliked dolls and playing house and preferred to play with guns and boys games, and saw themselves as tomboys ($p < .05$).

The nonclinical research shows that lesbians tend to have poorer relationships with both parents (Kenyon, 1968b; Siegelman, 1974; Thompson, et al., 1973).

Kenyon (1968b) found that lesbians saw their parents as being less happily married than the heterosexual women. There was a significantly higher percentage of divorce and separation in the experimental group than in the control group (homosexuals, 22.8%/heterosexuals, 4.9%). The homosexual parents were also more rejecting and less accepting about sexual matters ($p < .05$).

Thompson, et al. (1973) found that the mothers of lesbian women were described as close binding and intimate, as well as dominant and minimizing toward the father. While

the father was seen as detached and hostile toward the child. This has been the classical model of family interrelationships in the development of male homosexuality (Bieber, Dain, Dince, Drellich, Grand, Gundlach, Kremer, Rifkin, Wilbur, & Bieber, 1962).

The lesbians as children and adolescents often physically fought with other children, they tended to play base ball and had an athletic build. They did not completely accept their fathers, nor did they feel that their mothers completely accepted them. The homosexual women were more distant from both parents, as well as from males and females in general. However, they did see themselves closer to the female role than the male role. Lesbians, according to Thompson, et al. (1973) are distant and alienated from people in general.

Hassell and Smith (1975) did not find any evidence of gender identity confusion in their sample of homosexual women.

Both the clinical and nonclinical research show that lesbians have poorer relationships with both parents (Bene, 1965; Kenyon, 1968b; Siegelman, 1974; Thompson, et al., 1973). There was also a tendency for lesbians to view themselves as less feminine and less accepting of the feminine role (Kaye, et al., 1967; Kenyon, 1968b; Thompson, et al., 1973).

III SUMMARY

The genetic and hormonal studies have been few, as well as inconclusive. It cannot be concluded that genetics or hormones are insignificant in the etiology of female homosexuality.

The psychodynamic approach to the study of female homosexuality has been the most dominant and productive in this area. However, most of the variables that have been identified as significant in the development of female homosexuality have not been examined by current researchers.

Current research with clinical and nonclinical groups have shown that lesbians have poorer relationships with both parents, they experience more interparent friction and less family security, and feel less feminine and are less accepting of the feminine role than heterosexual women.

The research has shown some common trends, but these need to be explored in more detail with more diversified groups.

CHAPTER IV

PSYCHOPATHOLOGY AND FEMALE HOMOSEXUALITY

The psychopathological implications of female homosexuality, if any, are extremely controversial issues in psychiatry and psychology. Most early and current opinions on the psychopathology of female homosexuals are based on small and biased clinical samples (See Chapter I). The generalizability of their results to gay women in general have been criticized in this review, as well as by other investigators (Green, 1972; Hoffman, 1972; West, 1970).

Fort, Steiner, and Conrad (1971) mailed questionnaires to 63 social workers; 50 psychologists; and 50 psychiatrists in the San Francisco bay area. Approximately 90% of the questionnaires were returned from each group. Their results showed that 83% would classify homosexuality as a sexual deviation, while 73% would label homosexuality as a personality disorder. Thirty five percent would classify homosexuality in the same category as transvestism, pedophilia, sadism, and fetishism, while 33% would categorize homosexuality as a sociopathic personality disturbance.

Even though 64% of their sample would not classify homosexuality as a disease; psychogenic or functional disorders are normally perceived as a disease by 54% of the psy-

chiatrists and 28% of the psychologists. It appears that there is still a large contingency of mental health professionals who may still feel that homosexuality is a disease. However, 98% do feel that it is possible for homosexuals to function effectively.

Gartrell, Kraemer, and Brodie (1974) surveyed the 908 members of the Northern California Psychiatric Association with a return rate of 42%. This study was designed specifically to study psychiatrists opinions and views of female homosexuals. They found that 87% believed that lesbians can be well adjusted and 66% were opposed to the use of psychiatric labels and the sickness model.

The results from Morris' (1973) study indicated that only 6% considered homosexuality as a disease; 71% an abnormal behavior pattern and 35% viewed it as a normal variant like left handedness, which includes 44% of the psychiatrists and 26% of the general practioners polled.

Barr and Catts (1974/1975) surveyed 100 psychiatrists and 93 psychiatric trainees in New South Wales. Eighty-seven percent of the psychiatrists and 74% of the trainees responded. They found that 52% of the psychiatrists and 60% of the psychiatric trainees felt that homosexuality was a developmental anomaly that is not necessarily or commonly associated with neurotic symptoms.

Davison and Wilson (1973) examined the attitudes of 149 randomly selected members of the Association for the

Advancement of Behavior Therapy and all 75 members of the British Behavior Therapy Association toward homosexuality. Thirty-eight percent of the questionnaires were completed and returned. It was surprising to find that a small percentage of behavior therapists would attempt to change a homosexuals sexual orientation against his/her will (13%). This minority of therapists were also unwilling to believe that homosexuals could be happy and well-adjusted.

The investigators also found a negative relationship between exposure to homosexuals and attitudes. Those therapists who had attended a homophile meeting were unwilling to believe that homosexuals could be happy and well adjusted. However, the majority of the sample (91%) felt that homosexuals could be well-adjusted and happy, while 87% did not consider homosexuality as evidence of psychopathology.

These surveys (Barr & Catts, 1974/1975; Davison & Wilson, 1973; Fort, et al., 1971; Gartrell, et al., 1974; Morris, 1973) are deficient in a number of ways. There were no probing questions which would elicit minority opinions. For instance, the statement "Lesbians can be well adjusted" is much different than "Lesbians are well adjusted" or "Most lesbians are well adjusted." It was possible for respondents to acknowledge the possibility of homosexuals being well-adjusted, but in actuality give it a low probability of occurring. Other examples are: "It is possible for homosexuals to function effectively" (Fort, et al., 1971); "My con-

cept of mental health includes the possibility of a well-adjusted homosexual woman" (Gartrell, et al., 1974); and, "Homosexuals can be well adjusted and happy" (Davison & Wilson, 1973).

Many of the questions contained in these surveys were poorly formulated and lacked follow-up questions. Only one study examined professional attitudes toward female homosexuals (Gartrell, et al., 1974), while the other studies did not specify. They tapped crucial and controversial areas, but did not explore them in depth.

On one side, investigators have argued that homosexuality is an inherently "sick" condition and is not dependent on cultural acceptance (Bergler, 1948; Brody, 1943; Ellis, 1955), whereas other clinicians see the problems that homosexuals experience being the result of being different and living in an ostracizing society (Adler, 1967; Marmor, 1972).

Those favoring a disease, sickness, neurotic or degenerative model of female homosexuality have been extremely prolific in their writing (Adler, 1967; Allen, 1952, 1954; Barahal, 1953; Bergler, 1948, 1958; Bieber, et al., 1964; Brody, 1943; Burrow, 1917; Ellis, 1955; Gershman, 1953, 1957, 1966; Gluckman, 1966; Mayer, 1950; Oberndorf, 1919, 1929; Owensby, 1941; Piotrowski, 1967; Robinson, 1914; Rottersman, 1961; Socarides, 1970, 1972; Stekel, 1930; Symonds, 1969; Weiss, 1957). Bergler (1948) sees homosexuality as a "dis-

ease, no more and no less mysterious and fascinating than a severe case of typhoid fever" (p. 197).

The studies with clinical samples have been evaluated and shown to be unrepresentative of gay women in general (refer to Chapter I). It cannot be concluded from their research that lesbians are suffering from a neurotic, psychotic, or pathological condition. Likewise, nonclinical research is equally unrepresentative (refer to Chapter I). Some researchers have found homosexual samples to be more neurotic than the control group (Kenyon, 1968a), while others have found lesbians to be less neurotic or within the normal range (Armon, 1960; Freedman, 1967; Ohlson & Wilson, 1974; Wilson & Greene).

Investigators, using nonclinical samples have examined homosexual and heterosexual subjects to determine if there were demonstrable personality differences between the two groups; they have also studied the degree of psychological adjustment (Freedman, 1967; Hassell & Smith, 1975; Hopkins, 1969; Kenyon, 1968a; Wilson & Greene, 1971).

Hassell and Smith (1975) used the Draw-A-Person Test and the Adjective Checklist and found that lesbians in comparison to the heterosexual controls scored significantly higher on Autonomy, Exhibition, and the Change Scale, while significantly lower than the controls on Abasement, Deference, Self Control, Personal Adjustment, Defensiveness, Order, and Endurance.

Both groups shared similar attitudes toward males and females in general, but the homosexual group had a more positive attitude about themselves ($p < .05$).

Hopkins (1969) found that lesbians, in her sample, were more independent ($p < .01$), resilient ($p < .01$), reserved ($p < .01$), dominant ($p < .01$), bohemian ($p < .01$), self sufficient ($p < .01$), and composed ($p < .01$) on Cattell's 16PF.

Wilson and Greene (1971) using the California Psychological Inventory and the Edwards Personal Preference Schedule found that their sample of gay women were significantly higher on Dominance, Capacity for Status, Good Impression, Intellectual Efficiency, and Endurance.

Freedman (1967) examined the psychological adjustment of 62 homosexual and 67 heterosexual women. He administered the Eysenck Personality Inventory and the Personal Orientation Inventory to both groups. He did not find any significant differences in rated psychological adjustment and neuroticism. The experimental groups did score significantly higher on Inner Direction (person is guided more by her own internal values than by external influences), Self Actualizing Value, Existentiality (to react without rigid adherence to principles), Feeling Reactivity (sensitivity of responsiveness to one's own needs and feelings), Acceptance of Aggression (ability to accept one's natural aggressiveness as opposed to defensiveness, denial, and repression of aggression), and Capacity for Intimate Contact (ability to

develop meaningful relationships with others unencumbered by expectations and obligations). The homosexual group was less defensive and more candid about themselves than the heterosexual group.

Kenyon (1968a) used the Maudsley Personality Inventory and the Cornell Medical Index Questionnaire. He found that the homosexual group scored significantly higher on the Neuroticism Scale ($p < .001$) than the heterosexual group. However, he did not interpret his results.

Wilson and Greene (1971) did not find any pathological patterns between the two groups. In fact, both the experimental and control groups scored close to the means on all three tests (California Personality Inventory, Edwards Personal Preference Schedule, and the Eysenck Personality Inventory).

I SUMMARY

It cannot be concluded that homosexuality and psychopathology are synonymous, because there is evidence associating homosexuals with psychological adjustment (Freedman, 1967; Wilson & Greene, 1971). It is apparent that homosexuals are a diverse and variegated population who cannot be categorized or broadly labeled as sick, neurotic, or suffering from an inherently pathological condition.

Researchers who have studied personality characteristics of homosexual and heterosexual samples have found a

broad range of characteristics. It is undetermined at this point, whether or not there are stable personality differences between the two groups. The differences may be the result of poor sampling or because the experimenters did not control for gender role preference, etc., rather than any meaningful differences between homosexual and heterosexual women.

CHAPTER V

TREATMENT OF FEMALE HOMOSEXUALITY

Currently, the treatment of homosexuals is being debated on moral, ethical, and philosophical grounds. The area of controversy, very broadly, is whether or not the metamorphosis of a homosexual into a fully functioning heterosexual is even possible, which is not clear at the present time, and secondly, whether or not the majority of homosexuals seek therapy to become heterosexual.

Fort, et al. (1971) found that a significant majority of their sample of psychotherapists did feel that it is possible to change a homosexual's sexual orientation (72%), but more are unwilling to attempt such a treatment goal (43%), than are willing (38%). Whether or not these mental health professionals would attempt to change a homosexual's sexual orientation depends on certain indicators. Over 60% would attempt to change the clients sexual orientation if the client preferred and was making heterosexual contacts, while nearly 80% would require the absence of homosexual relations and 22% of the sample would require additional information before undertaking such a treatment goal.

Approximately 50% of the psychologists and 54% of the

psychiatrists indicated success in changing some of their client's sexual orientations (this is unexplained, because it may simply mean a decrement in homosexual behavior), while only about one third of the social workers indicated success. However, only 34 out of 165 respondents had success with those clients who were exclusively homosexual.

Fourteen percent of the Fort, et al. (1971) sample felt group therapy was the best therapeutic strategy, but 61% favored group therapy coupled with individual psychotherapy. Individual psychotherapy was the treatment indicated by 87% of Gartrell, et al. (1974) sample.

Davison and Wilson (1973) found that the mean success percentage in decreasing homosexual behavior was 60%, while 46% of their clients showed a significant increase in heterosexual behavior. The behavior therapists polled preferred and utilized aversive conditioning (45%), while only 16% preferred systematic desensitization.

There is an apparent lack of knowledge among behavior therapists concerning homosexuality, according to Davison and Wilson (1973). For instance, therapeutic strategies do not differ regardless of the person's sex for the majority surveyed (62%), nor does previous or current heterosexual involvement for 37% of the sample. Many do not assess specific sexual behaviors of their clients (27%) and of those who do, 82% were unable to indicate how this knowledge affect their treatment strategy.

It was striking to find that 13% would attempt to change a homosexual's sexual orientation against their will. This small percentage of behavior therapists were also unwilling to work toward helping the client feel more comfortable and at ease with their homosexuality or work on other problems than their homosexuality.

Morris' (1973) study of psychiatrists and general practitioners revealed that psychiatrists were more inclined to help the homosexual client become more at ease with their sexual orientation. Fifty-eight percent of the total sample, however, were willing to work on other problems than the persons homosexuality.

In reviewing the treatment literature this reviewer found a paucity of material on female homosexuality. Most of the literature, whether psychoanalytic, existential, or behavioral, have reported on the treatment methods used with male homosexuals rather than lesbians (Barlow & Agras, 1973; McConaghy, 1971).

Blitch and Haynes (1972) state:

The degree to which the theories and techniques derived from the study of male homosexuals are applicable to female homosexuality is an unanswered question. (p. 319).

Historically, the techniques employed were usually quite vague and often times very simplistic. Krafft-Ebing (1965), for instance, used hypnosis to help modify homosexual behavior. He reinforced heterosexual feelings (unexplained), while he removed the compulsion to masturbate,

which he felt was a critical variable in the etiology of homosexuality.

Despite the lack of effective methods in modifying a person's sexual orientation, early psychiatrists firmly believed that most homosexuals could make the transition to heterosexuality, if they so desired, with the aide of therapy (Brill, 1935; Meagher, 1929; Stekel, 1930). Many contemporary clinicians also believe that motivation is one of the most important variables in the modification of a person's homosexual behavior (Bieber, 1969; Report by the Committee on Public Health, 1964; Socarides, 1972).

It has not been until recently that researchers have attempted to employ specific behavioral (systematic desensitization, covert sensitization, aversive conditioning, etc.), and psychotherapeutic techniques in changing a person's sexual orientation and then compare the efficacy of these various treatment strategies (Callahan & Leitenberg, 1973; McConaghy & Barr, 1973; Meyer, 1966). Of course these studies have used male homosexuals instead of lesbians or a combination of male and female homosexuals.

There have been a small number of studies that have used female homosexuals, but they are methodologically deficient in a number of ways (Blitch & Haynes, 1972; Covi, 1972; Ellis, 1956; Rutner, 1970; Stone, Schengber, & Seifried, 1966). Not one of these studies used a control group or standardized instruments to measure the degree of

change in sexual orientation, nor were there adequate follow-up studies.

I SUMMARY

The treatment of female homosexuality in psychology and psychiatry has almost been completely neglected. Most of the literature has dealt with male homosexuals rather than lesbians. It cannot be concluded from the studies with males that the same techniques and theories are equally applicable to female homosexuals. The research that has been completed to date has been sparse and inadequate.

Considerable research needs to be conducted to assess the efficacy of different treatment strategies with female homosexuals.

The topic of treatment and changing a homosexual's sexual orientation has currently become an unpopular subject for many clinicians and homosexuals (Weinberg, 1973); however, psychology and psychiatry have an ethical responsibility to help those homosexuals who no longer or have not found their sexual orientation as a viable and satisfying alternative.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

I SUMMARY

It has been shown that both the clinical and nonclinical research samples are extremely biased. Historically and currently the clinical researchers have utilized small samples drawn from unspecified or unrepresentative populations. This type of research is usually in the form of case studies and has been psychoanalytically oriented. Currently, clinical researchers have attempted to overcome the methodological problems by using control groups, standardized tests, statistical analysis of data, etc. However, adequate clinical studies have been few and their findings highly tentative (Kaye, et al., 1967; Swanson, et al., 1972). The most serious problem with the clinical research is the inadequate sampling.

Nonclinical research, on the other hand, has used samples comprised of young, white, educated, and middle class subjects (Hassell & Smith, 1975; Wilson & Greene, 1971), thereby excluding upper and lower class subjects, as well as ethnic groups and less educated lesbians.

Researchers have attempted to find objective criteria that would discriminate between heterosexual and homosexual

women, using projective techniques (Hopkins, 1970) and self report inventories (Ohlson & Wilson, 1974), but their results are inconclusive. Data has shown, however, that there are significant differences between "butch" and "fem" lesbians and male homosexuals (Clingman & Fowler, 1976). Future research will need to determine the sex role preference of both the homosexual and heterosexual groups, otherwise differences between the two groups may be the result of a larger proportion of "butch" lesbians being compared to "fem" heterosexuals.

The etiology of female homosexuality has been an enduring topic in psychology and psychiatry. To date, researchers have not found any genetic or hormonal abnormalities to account for the phenomenon of homosexuality among women. Research focusing on the psychodynamic aspects of homosexuality have found that lesbians have poorer relationships with both parents, they experience more interparent friction and less family security, and feel less feminine and are less accepting of the feminine role than heterosexual women. Although these are statistically significant differences between heterosexual and homosexual women it is unknown how they affect the development of homosexuality, if they play a part at all.

Female homosexuality has been considered by many mental health professionals as a disease, neurosis, or degenerative condition (Bergler, 1948; Krafft-Ebing, 1965;

Socarides, 1970, 1972). The data has failed to show that that female homosexuals are less well-adjusted than heterosexual women (Freedman, 1967; Hopkins, 1969; Wilson & Greene, 1971).

The treatment of female homosexuality has almost been completely neglected. The majority of the literature has reported on the techniques and theories used on male homosexuals. The few studies that have used female homosexuals are methodologically inadequate (Blitch & Haynes, 1972; Covi, 1972; Ellis, 1956; Rutner, 1970; Stone, Schengber, & Seifried, 1966). They did not use control groups, standardized instruments to measure the degree of change of sexual orientation, or adequate follow-up studies. Extensive research needs to be completed to determine if the techniques and theories derived from the treatment of male homosexuals are also applicable to lesbians.

II CONCLUSIONS

It has become apparent in the course of this review that psychiatrists and psychologists have been primarily concerned with four basic questions: a) What is the etiology of homosexuality? b) Are homosexuals sick, diseased, neurotic, or degenerate? c) Are there clear signs and symptoms of homosexuality that differentiate them from heterosexuals? d) Can homosexuals be cured? Can they eventually achieve heterosexual adjustment through the application of various treat-

ment strategies?

These questions have preoccupied mental health professionals for the last 100 years. However, in the process other important and crucial areas have been neglected. Psychologists and psychiatrists have been too concerned with psychopathology in the area of female homosexuality.

Future researchers will need to broaden their research.

Some possible areas are: The effects of aging upon lesbians. How does the gay community react to elderly lesbians? Are the support systems in the gay community geared for young lesbians rather than elderly lesbians? Not one study has appeared in the literature concerning lesbians and the aging process.

Another area which has not been explored is lesbians and their offspring. Many female homosexuals have children, yet not one study has appeared in the psychological literature in this area.

The list of areas for future research is inexhaustible. Researchers will need to come out of their psychological cocoons and begin to take into consideration the variables and factors that have primarily concerned sociologists and social psychologists. The phenomenon of female homosexuality cannot be adequately understood apart from the social context.

III RESEARCH RECOMMENDATIONS

The area of human sexuality is extremely difficult to re-

search, because it is almost impossible to get a random sample. In the area of female homosexuality researchers have used volunteers which have been recruited through homophile organizations (Freedman, 1967; Hopkins, 1969), students who have contact with the gay community and then act as intermediaries (Wilson & Greene, 1971), etc.

There are a number of areas that future researchers will need to consider very carefully to insure a sound methodological study.

Contemporary researchers utilizing clinical and nonclinical samples have not been as concerned as they should be about sampling. If homophile organizations, gay bars, gay baths, etc., are the main source for subjects then the researcher should make an attempt to get the most representative sample he/she can. Homophile organizations, for example, have mailing lists which the experimenter may be able to use in order to get a random sample.

It has been shown in Chapter I that homosexuals can range from largely homosexual, but with distinct heterosexual history (score of 4 on the Kinsey Rating Scale) to entirely homosexual (score of 6 on the Kinsey Rating Scale). Kenyon (1968a, 1968b), for instance, found that 96% of the controls were exclusively heterosexual, while only 37.4% of the experimental group were exclusively homosexual. If an exclusively heterosexual group is going to be used then the experimenter should make certain that the experimental group

is exclusively homosexual.

Another extremely important area is sex role preference. Clingman and Fowler (1976) found significant differences between "butch" and "fem" lesbians and male homosexuals across and within groups. It is possible that personality differences that have been found between heterosexual and homosexual women (Hopkins, 1969) may be the result of "butch" lesbians being compared to "fem" control subjects. Sex role preference needs to be determined in both the experimental and control groups to insure equality.

Other variables controlled also need to be considered very carefully, for example, Freedman (1967) used volunteers from a national service organization who were middle age, married, had children, and were unemployed, whereas, his experimental group were lesbians who were young, unmarried, without children, and financially self sufficient. From his data he concluded that the experimental group had more of a masculine attitude toward work than the control subjects; however, since he did not have an adequate control group it is unknown if heterosexual women with similar characteristics as the experimental group would also be more masculine in their attitude toward work.

To insure that results are significant differences between similar populations researchers need to be more selective about the control subjects and variables controlled.

Sound methodological research in the area of female homo-

sexuality is in the incipient stages. Future researchers will need to become familiar with the methodological problems of doing research in this area.

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